

Dominion Dental Services, Inc., P.O. Box 75314, Charlotte, NC 28275-0314											
Subscriber Enrollment Information											
Social Security Number			Last Name		First		M.I.		Sex		
Home Address			City		State		Zip		Home Telephone		
Date of Birth - -		Dental Office Code # and Name (As indicated on your Provider Directory)						Work Telephone			
Dependent Information (List Covered Dependents Only)											
Last Name (if Different) First		M.I.	Sex	Birthdate	Soc. Sec. #	Last Name (if Different) First		M.I.	Sex	Birthdate	Soc. Sec. #
Spouse						Child					
Child						Child					
Child						Child					
Signature											
If I am voluntarily paying 100% of the cost of this Plan, without employer contribution, I agree to remain in Plan a minimum of 12 months and/or be responsible for a minimum of twelve months of Subscription Dues. I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to my covered dependents or me by dentists and other providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of Quality Assurance and/or utilization review. Authorization will be limited to the term of coverage of this policy. A copy of this form will be made available to subscriber or their authorized representative upon request.											
Subscriber's Signature X								Date			
Code #	Group #	Group Name				Coverage Eff. Date		Plan #			
		Stafford County Public Schools						607x			